# Special Articles and Association Notes

**The Manitoba Medical Association Review**

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*Editorial or other opinion expressed in this Review is not necessarily sanctioned by the Manitoba Medical Association*



## The Annual Meeting

ON another page will be found the Programme for the Annual Meeting of the Association. This year the meeting will be at the beginning of the week — Monday, Tuesday and Wednesday, September 11th, 12th and 13th.

There are not so many papers on the programme as in some former years, but the subjects dealt with are of fundamental importance and more time has been allowed for discussion. The general outline of the programme is arranged in order that there will be an opportunity for relaxation and entertainment.

We are fortunate this year in having several eminent visitors, and a perusal of the programme will show that the subjects they have chosen for discussion are of practical importance to the general practitioner. We are indebted to the Canadian Medical Asociation for sending us six clinicians. Through the co-operation of the British Columbia Medical Association it has also been aranged to exchange a speaker with Vancouver. Our association is very grateful to the visitors for the contribution which they are to make to our programme.

Each morning is devoted to scientific and clinical subjects. On Monday and Wednesday mornings papers will be presented at the Royal Alexandra Hotel. On Tuesday morning there will be a demonstration of clinical cases in the large theatre at the Medical College. Cases will be described by members of the staffs of local hospitals and discussed by the visiting clinicians. The cases will not be limited to one department of medicine, but will be as representative as possible of all fields of practice, and an effort has been made to choose types that illustrate methods of diagnosis and treatment of assistance in every day practice.

As there is to be a special meeting on Economics Monday evening, it was decided that the afternoon should be left free for entertainment. The Garden Party will be held at the Motor Country Club, Lower Fort Garry, and both the doctors and their wives are expected to attend. Lower Fort Garry is one of the most picturesque sites near Winnipeg, and the Garden Party should provide a unique opportunity for meeting friends and exchanging news and views on medical and other topics. His Honour, The Lieutenant-Governor, and Mrs. Tupper have graciously consented to attend the Garden Party. The provision of a Garden Party is a new venture in connection with the Annual Meeting, and it is hoped that it will be enjoyed by all the members and their wives.

On Tuesday afternoon the Presidential Address will be given immediately following luncheon, and the remainder of the time will be used for the Annual General Meeting.

Wednesday afternoon will be devoted to golf. Through the courtesy of the Board of Directors, the Committee have arranged that the Annual Golf Tournament will be at Pine Ridge Golf Club. This is one of the best courses in Manitoba, and all golfers should look forward with pleasure to this tournament.

Monday evening will be given over to a special meeting on Medical Economics. This is a subject which is becoming of more importance to the profession every day. There has been much discussion of various aspects of medical economics by the laiety. Although in many cases this has been of the nature of special pleading rather than a dispassionate analysis of the problems involved, yet it makes it all the more necessary that the profession should be well informed on this subject. This year we will have with us Mr. Hugh H. Wolfenden, F.I.A., F.A.S., F.S.S., the Consulting Actuary and Statistician. Mr. Wolfenden has been retained as consulting actuary by the Canadian Medical Association, and arrangements have been made for him to attend the meetings in the four western provinces. The meeting will open with brief discussions of special phases of medical economics by Doctor E. S. Moorhead, Doctor F. W. Jackson and Doctor J. A. Hannah. Mr. Wolfenden will then deal with the subject in a broad sense, and later the meeting will be thrown open for general discussion. As this meeting is a new feature of the Annual Meeting of the Association, it is hoped that members will

avail themselves of the opportunity to learn something about questions relating to the economic aspects of medical practice.

The Annual Dinner and Dance on Tuesday evening will have all the usual features, and in addition the Committee are arranging special entertainment. The Committee have arranged the details with great care and hope that it will be a specially enjoyable feature this year.

The Committee on Scientific Exhibits have arranged an interesting series of exhibits, including pathological, radiological, microscopic and other features. Those submitting the exhibits have been asked to be in attendance to explain them to the members. Intermissions have been arranged in order that the members may have time to devote to examination of the scientific and commercial exhibits.

The Ladies' Committee have been working very hard in arranging for the entertainment of the doctors' wives. The usual afternoon tea will be replaced this year by the Garden Party at Lower Fort Garry. On Monday evening there will be bridge for the wives of visiting doctors at the residence of Mrs. S. G. Herbert. Those wishing to play golf may arrange to do so on Wednesday morning. Mrs. W. S. Peters will give a luncheon to the wives of the members of the retiring executive on Tuesday at the Manitoba Club, and of course there is the Dinner and Dance on Tuesday evening.

Altogether the plans that have been made indicate that our Annual Meeting this year should be not only a valuable means of widening our medical knowledge, but also provide a welcome opportunity for a brief holiday from the cares of practice.

## Montreal Meeting of the Canadian Medical Association

The Montreal meeting of the Canadian Medical Association during the week of the 19th was one of the most successful in the history of the association. Everyone was very much impressed with the great deal of care taken by the local committee in preparation for the meeting. There were over two hundred contributions to the programme, and there were one thousand and eighty-five practitioners registered at the meeting.

The General Council met the first few days under the chairmanship of Doctor T. H. Leggett of Ottawa.

Council adopted the consolidated constitution and by-laws after the report had been presented by Doctor R. I. Harris of Toronto.

The chairman of the Committee on Economics, Doctor Wallace Wilson, of Vancouver, presented a comprehensive report. The Association engaged Mr. Hugh H. Wolfenden, Consulting Actuary, to assist the Committee on Economics in its work for the coming year.

Ten senior members were elected, including Doctor W. Harvey Smith, of Winnipeg.

The Association accepted the proposal from the Canadian Broadcasting Corporation to provide thirty-two broadcasts during the coming year, each of fifteen minutes' duration.

The time and place of the annual meeting have been fixed for the next two years—

1940 in Toronto, during the week of June 17th.

1941 in Winnipeg, during the week of June 22nd.

In 1942 the meeting will be held in Alberta, location and date to be decided later.

Immigration, particularly referring to the admission of refugee doctors, provoked considerable discussion. It was the feeling of General Council that, while the Association is very sympathetic with our medical colleagues in some other lands for the plight in which they find themselves, Council is of the opinion that the medical schools of Canada are graduating more than a sufficient number of doctors for Canadian needs, and therefore, Council could not support or justify the importation or admission of refugee doctors into Canada for the specific purpose of practising medicine.

Excellent reports were presented by the various standing and special committees, including the Hospital Service Department, the Committee on Schools for Laboratory Technicians in Canada, the Maternal Welfare Committee, the Committee on Medical Education, the Committee on Public Health, the Committee on Nutrition and the Committee on Legislation. The reports touched upon a great many points of interest which will be detailed in the September *Journal*.

Among the distinguished visitors to the meeting were Sir Arthur MacNalty, Chief Medical Officer, Ministry of Health for Great Britain, London, England; Professor Edward Provan Cathcart, Professor of Physiology, University of Glasgow; Dr. Thomas S. Cullen of Baltimore, fraternal delegate of the American Medical Association; Dr. Allen O. Whipple of Columbia University, New York, who gave the Lister lecture.

On the entertainment side the men, women and young people were exceedingly well cared for. The members of Council were dinner guests of the Quebec Division, the Montreal Medico-Chirurgical Society and La Societe Medicale de Montreal on Tuesday night. On Wednesday night the Association had the unique experience of a delightful entertainment at the Chalet on the top of Montreal Mountain, motor transportation being permitted, which in itself was a great privilege, as rarely have motor cars been allowed on the mountain top. Fortunately, the night was clear, making the view of the city, lying well below, most attractive. More than 1,000 people were received by the President and Mrs. Patch.

Again on Thursday night the members and their ladies enjoyed a splendid dance and floor show on the Normandie roof of the Mount Royal Hotel.

Too much praise cannot be given the committees for the magnificent organization which they had set up, which functioned so smoothly in providing delightful entertainment for their guests.

## OBITUARY

Dr. Charles Warwick McVicar, aged 39, died in Winnipeg on August 11. Born in Cornwall, Ont., he came to Western Canada with his parents when he was a boy, was educated at Winnipeg and Regina and graduated from the Manitoba Medical College in 1923. He practiced at Vanguard, Sask., for several years; took post graduate work in London, and spent two years on the staff of the Radium Institute in Manchester. Later he was appointed radio-therapist to the Otago General Hospital in Dunedin, New Zealand. He had returned to Winnipeg in July of this year to start practice in radio-therapy.

The American Congress on Obstetrics and Gynaecology will meet at Cleveland, Ohio, September 11-15, 1939. Applications for membership should be sent to 650 Rush street, Chicago, Ill., U.S.A.

## NOTICE

The Board of Trustees of The Winnipeg General Hospital invites applications for appointment to the position of Assistant Ophthalmologist.

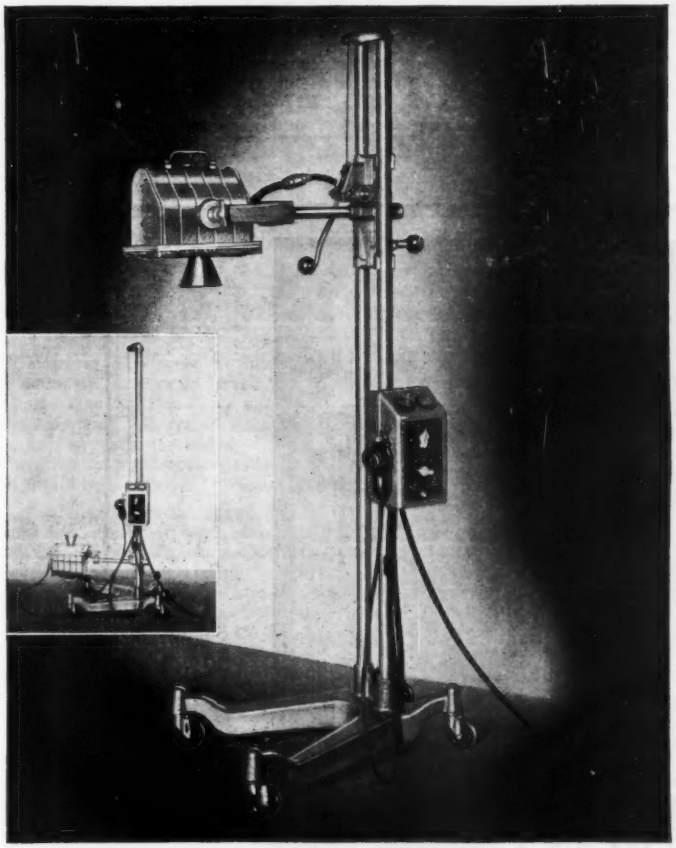
These should be in by October 1st, 1939.

G. F. STEPHENS, M.D.,
*Superintendent.*

The University of Wisconsin Medical School has arranged a programme of scientific papers for the Institute for the consideration of the blood and blood-forming organs September 4th, 5th and 6th. The programme is an excellent one with many distinguished contributors and should be of value to all medical men interested in Haematology.

The thirty-ninth Annual Meeting of the Canadian Tuberculosis Association will be held at the Royal Alexandra Hotel, Winnipeg, September 7th, 8th and 9th preceding the meeting of the Manitoba Medical Association. A large number of very interesting papers will be presented and a large attendance is expected.

**OFFICE SPACE TO LET.**—Good location for medical man in Elmwood to share office space with well-established dentist.—Apply Box 200, "The Manitoba Medical Review," 102 Medical Arts Bldg., Winnipeg.



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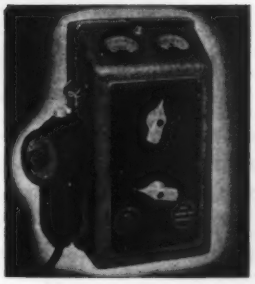

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# Department of Health and Public Welfare

## NEWS ITEMS

THE PREVENTION OF SKIN DISEASES IN CHILDREN: The following article by George Clinton Andrews, Associate Professor of Dermatology, College of Physicians and Surgeons, Columbia University, New York, was recently published in the publication "Preventive Medicine" and we are quoting it herewith, trusting our readers will find it as interesting as we have:

"Many skin diseases in children are brought about by predisposing or contributory causes. It is important, therefore, that these should be recognized and combatted in an effort to prevent such diseases from developing. Lowered resistance of the body tissues, debilitation and malnutrition, as well as disorders of special organs, often have a direct bearing on cutaneous disturbances. Pruritus urticaria and eczema may be connected with disorders of the nervous system. The course of many dermatoses, including some of bacterial origin, is influenced by anemia and constipation.

"Some diseases are more prevalent in certain countries and climates and should be specially guarded against. While climate influences the incidence of skin diseases in our own country, the mode of living, the kind of food, and the habits of personal cleanliness in the family are the more important factors. In certain seasons attention should be given to the prevention of certain dermatoses. For instance, chilblains, eczema and psoriasis are aggravated during the winter, whereas prickly heat and hydroa vacciniforme are encountered in the summer.

"Heredity undoubtedly plays an important role as a predisposing cause. The distinction between hereditary and familial disease is not always sharply drawn. A predisposition to a disease or an hereditary weakness may be transmitted rather than the disease itself. On the other hand, syphilis may be directly transmitted. A knowledge of these potentialities may help to prevent infection with these diseases in children. Albinism and ichthyosis are considered hereditary diseases. Xeroderma pigmentosum, psoriasis and leukoderma sometimes affect several members of one family.

"Although the recognition and the avoidance of these factors may help to prevent the development of some of the skin diseases which have been mentioned, there are certain external causes of more practical importance. Household pets, especially cats and dogs, are the source of many dermatoses, the most common being ringworm and impetigo. Personal hygiene plays an important role. The excessive use of soap and water as well as their too frequent use may directly lead to pruritus and eczema, or indirectly prove an aggravating factor. Lack of bathing, on the other hand, predisposes to the development of certain parasitic diseases including ringworm, scabies, and pediculosis. Impetigo and furunculosis frequently occur where the integument is saturated with sweat and dirty from the accumulation of sebaceous material which forms a favorable soil for the growth of microorganisms.

"The amount of bathing must be individually regulated according to the character of the child's skin. Most children tolerate one or more baths a day during the summer months, but few can tolerate more than one bath a day during the winter months. There is a general tendency to overbathe children's bodies. Admitting the need for frequent cleansing of exposed parts such as the hands, knees and face, it is, nevertheless, not necessary to scrub the trunk vigorously and often enough to cause the skin of the chest and back to become dry and itchy. There is also an inclination to neglect drying the toes. This probably accounts for the development of most cases of dermatophytosis of the feet and hands. The fungi, which are the pathological agents, find an environment of warmth and moisture favorable for their growth on the toewebs and there form substances that are disseminated through the blood stream and cause the eruptions on the hands. Such diseases are essentially tropical but when they find an environment between the toes that approaches tropical conditions their growth there will naturally follow. Dryness between the toes can usually be maintained by the use of a dusting powder containing 1% thymol iodide which is applied after the careful use of a hand towel.

"Most of the good bath soaps on the market are mild and satisfactory. They are, however, drying, and should be thoroughly rinsed off. It is good practice to use as little soap as is necessary to make good suds which makes it possible to remove all the alkali thoroughly by careful rinsing.

"Care of the finger and toe nails deserves consideration. It is natural for children to play in the dirt and to be dirty, but it is inexcusable for parents to let them go to bed with dirty finger nails or dirty toe nails. The habit of biting the nails or picking the cuticle may lead to various paronychial infections and nail deformities. Apparently insignificant abrasions, scratches, and punctures if neglected may be the starting points of impetigo, ecthyma and pyogenic granuloma. Impetigo, boils and other dermatoses may also result from picking mosquito bites or other trivial skin lesions, particularly when the finger nails are dirty.

"Staphylococci present on normal skin may, by gaining access to deeper tissues, give rise to various other pyogenic diseases such as furunculosis, pyogenic granuloma and erysipelas. Since a single furuncle may be the forerunner of multiple abscesses, an attempt should be made to abort the furuncle in its early stage. This is best accomplished by the application of a protective dressing of an ointment consisting of phenol 4% in lead oleate plaster, and by the immediate institution of vaccine therapy.

"Where possible the child with pustular infections, especially impetigo, should be isolated from playmates. The prevention of spread of impetigo in institutions, especially maternity wards, deserves special emphasis. Infants with impetigo should receive a vigorous and complete inunction of the entire surface of the body with a 3% ammoniated mercury ointment. The treatment should be given daily, for three successive days. These infants should not be bathed with water again during their stay in the hospital. When diapers are changed no water is used, the genitalia and buttocks being carefully cleansed with absorbent cotton moistened with sterile cottonseed oil. To prevent the spread of impetigo in the nursery all contacts, that is, all other children in the nursery should be given a complete inunction with 3% ammoniated mercury ointment for three successive days. Also, on admission to the nursery every baby subsequently born is first to be given a cleansing bath with soap and water, then a single vigorous inunction with 5% ammoniated mercury ointment. On the following day the child is to be rubbed with sterile cottonseed oil.

"Care of the child's scalp is often neglected. On the whole, there is a tendency to wash the scalp too often and not to use enough oil upon it. The scalp should be washed about once a week during the hot summer months and once every two or three weeks during the winter time, olive oil to be applied to the scalp and thoroughly massaged into it at least once a week throughout the year. During the summer months if there is much swimming and exposure to the hot sun, the applications of oil should be made oftener so as to prevent excessive dryness that is often caused by these factors.

"Due to its exposed position and its protective function, the skin is liable to trauma. The degree of injury to the skin by physical agents varies widely. Scalds and burns are perhaps the worst types of injuries. They are sometimes fatal and in many instances lead to serious lasting deformity. They can come from many indiscretions and circumstances, but in general scalds result from hot soup, tea or coffee and severe burns from playing with matches or from playing with alcohol or gasoline. Tea pots, coffee pots and hot soup should not be placed within the reach of a child. It should be made a practice always to put such hot fluids far away from children. Matches should always be kept out of reach and sight of children. Sometimes children are too young to understand what is told them about the dangers of playing with matches. In such instances if they persist in playing with them it may be necessary to purposely light a match and burn them a little to show them how hot and dangerous it is. I have known one patient whose child was burned to death by playing with matches who thought it necessary to teach his other children in this manner.

"Trauma may be due to bites of insects, such as midges, flies, mosquitoes, stings of wasps and jelly fish. It is sometimes difficult to avoid such trauma. Children should be protected, particularly while sleeping. Bites by cats, dogs and even rats are important sources of disease. Many cases of rat bite fever, which is a spirillosis, have been encountered in children even in this country. Furuncular lesions due to botflies (myiasis) are not uncommon in the southern states and can be prevented by the use of netting over sleeping children. Infestation with hook worm larvae is often due to walking in bare feet on wet sand or damp ground.

"Dermatitis venenata is common in children. It may arise from exposure to poison ivy, poison sumach or other plants. It may also come from playing with lacquered articles or those made from teakwood or other irritative woods. Paints which are on playthings may cause dermatoses. Insecticides sprayed about to keep away mosquitoes, or flea powder or ant powder may cause similar eruptions. Rubber goods, plastics, and many other articles with which children come in contact may cause skin eruptions. The prevention of these may be accompished by a knowledge of the causative role which they may play. If there is known exposure to poison ivy or other external irritants, the exposed areas should be thoroughly washed with tincture of green soap. In the case of poisonous plants it is advisable in addition to cleanse the areas with gasoline followed by alcohol. These agents will suffice to dissolve and wash away the irritating substances but are of themselves somewhat harsh. Therefore, this cleansing should be followed by the application of a soothing remedy such as calamine and zinc lotion."

## COMMUNICABLE DISEASES REPORTED

**Urban and Rural - June 18th to August 12, 1939.**

**Measles:** Total 314—St. Boniface 145, Winnipeg 97, Shellmouth 10, Swan River Rural 9, Minitonas 7, Montcalm 9, Eriksdale 5, Swan River Town 5, unorganized 5, Grey 2, Hamiota Rural 2, Arthur 1, Brandon 1, Gilbert Plains Rural 1, Hanover 1, Kildonan W. 1, Oakland 1, Portage Rural 1, Rhineland 1, Riverside 1, Woodlands 1 (Late reported: Roland 7, St. Boniface 1).

**Tuberculosis:** Total 135—Winnipeg 25, Unorganized 14, Portage City 6, Brandon 5, Portage Rural 5, St. Boniface 5, Rockwood 4, St. Laurent 4, Siglunes 4, St. Clements 4, Lakeview 3, Lorne 3, St. Vital 3, Stanley 3, Armstrong 2, Bifrost 2, Brokenhead 2, Cartier 2, Dauphin Rural 2, Eriksdale 2, Fort Garry 2, Lac du Bonnet 2, Neepawa 2, Selkirk 2, Souris 2, Stonewall 2, Brooklands 1, Caldwell 1, De Salaberry 1, Emerson 1, Flin Flon 1, Franklin 1, Genella 1, Hanover 1, Hillsburg 1, Kildonan East 1, Morris Rural 1, Ochre River 1, Rhineland 1, Rossburn Rural 1, St. Andrew 1, St. James 1, Swan River Town 1, Strathcona 1, The Pas 1, Transcona 1, Turtle Mountain 1, Wawanesa 1, Woodlands 1.

**Chicken Pox:** Total 168—Winnipeg 47, Flin Flon 33, Unorganized 20, Rosser 8, St. Boniface 8, Pipestone 5, Kildonan East 3, Lorne 3, Minto 3, Brooklands 2, Gimli Village 2, Daly 1, Dauphin Rural 1, Labroquerie 1, Norfolk North 1, Portage Rural 1, Turtle Mountain 1, Victoria Beach 1 (Late reported: Flin Flon 23, Dauphin Town 1, Gilbert Plains Rural 1, Gilbert Plains Village 1, Victoria Beach 1).

**Whooping Cough:** Total 144—Winnipeg 65, St. Vital 11, Morris Rural 6, The Pas 6, Unorganized 6, St. James 5, Portage Rural 4, Montcalm 2, La Broquerie 1, St. Laurent 1, Transcona 1, (Late reported: Unorganized 23, St. Vital 9, St. James 4).

**Scarlet Fever:** Total 81—Winnipeg 23, Transcona 10, Brandon 5, Unorganized 5, Binscarth 3, Roblin Rural 3, Kildonan East 3, St. Boniface 2, Sifton 2, Springfield 2, Turtle Mountain 2, Brokenhead 1, Desalaberry 1, Oakland 1, Killarney 1, Morden 1, Pembina 1, Portage Rural 1, Rockwood 1, Rosser 1, St. James 1, Tuxedo 1, Virden 1, (Late reported: Springfield 3, Charleswood 2, Transcona 2, Lorne 1, St. Vital 1).

**Mumps:** Total 76—Winnipeg 46, Kildonan West 9, St. Francois 8, Unorganized 5, Kildonan East 2, Minitonas 1, St. Vital 2, Rockwood 1, Strathclair 1, Cornwallis 1.

**Diphtheria:** Total 44—Winnipeg 20, Bilfrost 8, Rhineland 7, Unorganized 3, Brooklands 1, Kildonan North 1, Kildonan W. 1, St. Clements 1, Stanley 1, (Late reported: Hanover 1).

**Influenza:** Total 25—Grandview Town 1, Shoal Lake Village 1, (Late reported: Brandon 2, Grandview Rural 2, Albert 1, Brokenhead 1, Cartier 1, Dauphin Rural 1, Dauphin Town 1, Ellice 1, Ethelbert 1, Harrison 1, Lac du Bonnet 1, Lorne 1, Louise 1, Odanah 1, Piney 1, Riverside 1, Russell Rural 1, Shellmouth 1, Shoal Lake Rural 1, Tache 1, Unorganized 1).

**Lobar Pneumonia:** Total 14—Brandon 1 (Late reported: Unorganized 3, Brandon 2, Brokenhead 1, Charleswood 1, Cypress South 1, DeSalaberry 1, Morden Town 1, Portage Rural 1, Selkirk 1, Winchester 1).

**Typhoid Fever:** Total 10—Portage City 1, Portage Rural 1, Rhineland 1, Unorganized 1, Winnipeg 1, (Late reported: Selkirk 3, Dauphin Town 1, Portage Rural 1).

**Erysipelas:** Total 9—Winnipeg 5, Minitonas 1, St. Boniface 1, Transcona 1, Unorganized 1.

**Anterior Poliomyelitis:** Total 5—Dufferin 1, DeSalaberry 1, Gimli Rural 1, Winnipeg 1 (Late reported: Unorganized 1).

**Diphtheria Carriers:** Total 3—Winnipeg 3.

**Trachoma:** Total 3—Pilot Mound Village 1, Swan River Rural 1, Unorganized 1.

**Tetanus:** Total 2—Morris Rural 1 (Late reported: Morris Rural 1).

**Lethargic Encephalitis:** Total 2—Unorganized 1 (Late reported: Blanchard 1).

**Pueperal Fever:** Total 1—Winnipeg 1.

**Smallpox:** Total 2—Brenda 1, Minnedosa 1.

**Septic Sore Throat:** Total 1—Portage Rural 1.

**German Measles:** Total 2—Hanover 1, Unorganized 1.

**Streptococcal Cellulitis:** Total 1—(Late reported: Springfield 1).

**Undulent Fever:** Total 1—Winnipeg 1.

**Venereal Disease:** Total 124—Gonorrhoea 63, Syphilis 61 (month of July).

**DEATHS FROM ALL CAUSES IN MANTOBA**
**for the Month of June 1939.**

URBAN—Cancer 49, Tuberculosis 11, Pneumonia (all forms) 4, Syphilis 4, Lobar Pneumonia 3, Septic Throat 2, Tetanus 2, Measles 1, Typhoid Fever 1, Cerebrospinal Meningitis 1, all others under one year 11, all other causes 149, Stillbirths 15. Total 253.

RURAL—Cancer 42, Tuberculosis 27, Pneumonia (all forms) 6, Lobar Pneumonia 6, Influenza 5, Lethargic Encephalitis 1, Puerperal Septicaemia 1, Septic Throat 1, Typhoid Fever 1, Whooping Cough 1, all others under one year 33, all other causes 158, Stillbirths 21. Total 303.

INDIAN—Tuberculosis 5, Pneumonia (all forms) 4, Cancer 1, all others under one year 6, all other causes 9, Stillbirths 1. Total 26.

## Medical Library
## University of Manitoba

**Post-Graduate Medical Journal — May, 1939**

The Investigation of a Suspected Case of Brain Tumour. By C. M. Hinds Howell, M.D., F.R.C.P., Consulting Physician, St. Bartholomew's Hospital; Physician, National Hospital, Queen's Square.

The Pathology of Intracranial Tumours. By Dorothy S. Russell, M.D. (Lond.), Member of Scientific Staff, Medical Research Council.
From the Bernhard Baron Institute of Pathology, the London Hospital.

Tumours of the Temporal Lobe of the Brain and their Treatment. By Cecil P. G. Wakeley, D.Sc., F.R.C.S., F.R.S.E., F.A.C.S., F.R.A.C.S. (Hon.), Fellow of King's College, London. Senior Surgeon King's College Hospital and the West End Hospital for Nervous Diseases. Consulting Surgeon to the Maudsley Hospital and to the Royal Navy. Hunterian Professor Royal College of Surgeons of England.

Tumours of the Frontal Lobe. By Geoffrey Jefferson, M.S., F.R.C.S. (Hon. Neurological Surgeon, Manchester Royal Infirmary; Hon. Surgeon, National Hospital, Queen Square, London).

Tumours of the Parietal and Occipital Lobes. By A. Dickson Wright, M.S., F.R.C.S., Assistant Surgeon, St. Mary's Hospital; Surgeon, Maida Vale Hospital.

Meningeal Tumours. By Harvey Jackson, F.R.C.S., Hon. Assistant Surgeon, National Hospital for Diseases of the Nervous System, Queen Square, W.1, and the West London Hospital; Consulting Neurological Surgeon, Queen Mary's Hospital, Roehampton.

Subtentorial Tumours. By Geoffrey Knight, F.R.C.S., Assistant Surgeon, West End Hospital for Nervous Diseases. Associate Neurological Surgeon, The Metropolitan Hospital, London. Consulting Neurological Surgeon, Southend General Hospital.

Hypothalamic and Pituitary Tumours. By Samuel Nevin, M.D., M.R.C.P., Assistant Neurologist, King's College Hospital, Assistant Physician, Hospital for Nervous Diseases, Maida Vale.

**The Clinical Journal — April, 1939**

The Less Common Abdominal Emergencies. By A. Kendle Short, Professor of Surgery in the University of Bristol.

Diverticulitis of the Colon. By R. J. McNeill Love, M.S., F.R.C.S., Surgeon, Royal Northern Hospital.

Causation and Treatment of Brachial Neuritis. By J. Barnes Burt, M.D., Physician, Royal Mineral Water Hospital, Bath.

Indications for the Use of Zinc Protamine Insulin. By R. E. Tunbridge, M.D., M.Sc., M.R.C.P., Honorary Physician to the Leeds Public Dispensary and Hospital, and Reader in Medicine at the University of Leeds.

**Glasgow Medical Journal — April, 1939**

Undulant Fever: A Review with a Report of a Case. By Alice K. Montgomery, M.B., Ch.B., Assistant Physician, Ruchill Fever Hospital, Glasgow.

A Critical Review of the Steinach II. Operation as a Method of Treating Prostatic Obstruction. By Arthur Jacobs, F.R.F.P.S., Urological Surgeon, Glasgow Royal Infirmary.

THE MANITOBA MEDICAL ASSOCIATION REVIEW
*Vol. XIX., No. 10, October, 1939.*

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# Clinical Section

## Infection in the Nasal Sinuses in Children and its Relation to Chest Infection*

*By*

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Efforts to correlate the existence of chest disease of the type with which we are dealing today, the so-called septic chest, with disease in the accessory nasal sinuses and to classify them as to origin or etiology has led to a considerable amount of controversial argument. Theories regarding the onset and the presence of chest infection of this nature and their relation to disease of the upper respiratory tract have been discussed very extensively without any very definite conclusions being formed.

In an analysis of a fairly large number of cases from our records and from observations I have been able to make in examining these children bronchoscopically and rhinoscopically, I am strongly of the opinion that in the vast majority of cases the onset of the disease is primarily in the chest and that the upper respiratory tract is only the port of entry of the organisms. The largest percentage of these children are infected and acquire the disease at a very early age, in the first year of life and in fact in some cases the infection begins at birth.

It seems to me that we must look for the cause of onset as in the case of asthma where an inherited predisposition exists and a certain percentage, large or small, must fall into this category. As a great majority of the cases occur in the poorer classes of people we must give our attention in this direction. Poor surroundings, improper care and nourishment have a definite bearing on its causation. In going into the history of these cases one almost invariably finds that the chest affection appears following whooping cough or measles or that the trouble started very shortly after birth from causes unknown to the parents, no doubt in this particular class of case secretions of mucus which cannot be expectorated give rise to a mild form of bronchitis or possibly pneumonia; this does not completely clear up and is constantly stirred up by fresh attacks of infection.

Attacks of bronchitis or brocho-pneumonia in early life that are repeated are other contributory causes. "The changes which take place in the bronchi are probably functional at first and later this leads to a permanent change due to the action of toxins and the stagnation of purulent secretions which destroy the normal function of the bronchial wall and allows fibrosis to fix the bronchi in a permanently dilated condition (bronchiactesis)." Jackson [1].

The infection in the nasal accessory sinuses, it seems to me, must follow or is secondary to the chest condition because at such an early age, in many cases, the sinuses do not exist. This may be very early age but only in a very rudimentary state of development. In older children, that is to say, above the age of four years, it is true the history of onset of a chest infection associated with infection of the upper respiratory tract is often elicited and is significant. Here the infection above may be the cause or it may be the result of the chest infection. We must not forget, too, that cases of chest sepsis are met with in this age group who do not exhibit symptoms or signs referable to the nasal sinuses. Then again if we look back over all the cases of sinus disease in children who do not exhibit any signs of chest infection we have no alternative but to conclude that when the disease does exist in both regions it is purely coincidental.

Authorities universally agree on the subject of development of the accessory nasal sinuses and tell us that the antrum at birth is only a very narrow slit-like space in the maxilla. The ethoids are the first cells to appear and are evident in early fetal life. The frontals do not make their appearance until about the second year of life according to Skillern.[2] Some interesting studies have been made on the sinuses of infants and children after death to determine the incidence of infection in these cavities. Ebbs[3] examined 300 cases of children who had died in the children's hospital at Birmingham and found that in approximately 30% of the cases there was infection in the nasal sinuses. Skillern also has reported and quoted others with results which closely correspond to the above; but do these observations give us information of any worth while value, or what conclusions are we to draw from them. Surely it is only to be expected that children with fatal illnesses are bound to have some infection in the upper respiratory tract. There is a strong possibility that these cavities are infected during the terminal stages of a fatal disease. When resistance is lowered the function of defence such as that of ciliary action and phagocytosis must necessarily be very much impaired.

The investigation of the upper respiratory tract must not be overlooked in any case of chest infection and cough which does not always manifest itself as an outstanding symptom of sinus disease. Cough in children and in adults is a manifestation of laryngeal, tracheal or bronchial irritation and may be brought about through many causes which are mechanical in nature. I will not attempt to go into the details of these many causes but shall confine my remarks to cough as a manifestation or symptom of sinus disease. Cough is not a constant or persistent symptom of disease in the nasal accessory sinuses, by any means, as I have indicated above but manifests itself only, as a rule, after the patient has been in the recumbent posi-

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tion for some time when secretions from the sinuses drop down and give rise to irritation in the larynx and trachea. During the day when the secretions are removed from the throat there may be little or no cough, so too, in hyperplastic conditions of the sinuses cough is not a prominent symptom.

### DIAGNOSIS

The diagnosis is important and one must endeavour to correlate the physical findings with other tests and aids and never, for instance, depend on roentgen findings alone. This error is too often made. We must remember that positive findings which the x-ray often reveals may mean nothing. I will show some x-ray films of the sinuses later which demonstrate these facts very definitely. Often x-ray films are taken of the sinuses for diagnostic purposes and treatment is instituted on these findings alone, a practice which should be emphatically condemned. The differential diagnosis of maxillary from anterior ethmoidal infection must be given the most careful attention. This applies likewise in the case of the other sinuses. Shadows or veilings over certain areas of the sinuses may mean nothing so far as active disease is concerned. A thickened mucosal lining may give rise to this finding on either one or both sides of the skull depending upon the effect and distribution of a previous infection which has subsequently become completely well. It is well known too that x-rays of the nasal accessory sinuses during an attack of hay fever will show an opacity over the sinuses that may be completely clear a day or so after the attack has subsided. Proetz has recently called attention to this fact. While roentgen ray is a very valuable aid in the diagnosis of sinus disease it must not be taken to the exclusion of the clinical findings.

Careful inspection of the mucosal lining of the nose is essential and the characteristic appearance of the membranes which is always present in hay fever and allergic conditions must never be overlooked. In many cases, no doubt, we can and do meet with infections which are superimposed on an allergic condition. In differentiating allergic from infectious cases one may be helped by the examination microscopically of nasal smears for the presence of eosinophils. I said may be helped, because I think the alleged significance of eosinophiles in the tissues and secretions has been over emphasized. Secretions and tissue removed from allergics will at times show many eosinophiles and at other times show none at all. When an infection is superimposed on a condition of allergy it of course must be dealt with in the usual way.

It would require much more time than is at our disposal today to cover in detail the many problems involved in diagnosis of disease in these important cavities. I need hardly say that I have already touched on a very few of the points which I have considered important.

### TREATMENT

And now we shall go to the subject of treatment. Many fads and fancies have been advocated in the years that have passed since the importance of these cavities have come to be recognized. I should like to have this opportunity to warn you against the indiscriminate use of nasal packs with drugs of all descriptions, such as silver, epiniphern, zinc, etc., and their use without regard to the condition which is underlying. This practice I emphatically deprecate. Many of the children who have been subjected to these measures would have gotten better anyway, others get better in spite of it. So let us not be too anxious about instituting treatment in many of these acute cases unless we are sure of the exact nature of the condition with which we have to deal. General hygenic conditions in many instances may be far more necessary and important than dropping this or that and other drug into the child's nose. If solutions must be used in the nose we must be careful to use physiological and isotonic ones. By the improper and indiscriminate use of drugs in the nose of both children and adults there is danger of bringing about a condition worse than that which we started out to treat. Remember that the function of the nasal mucus membrane which in regions is covered with epithelium which is highly specialized can be seriously interfered with and damaged by the improper use of drugs.

Investigations have been made recording the results of the application of some of the drugs which I mentioned a few moments ago to the mucus membranes of the nose over periods of time varying from a week to a month and it is interesting to know the changes which take place in the membranes. Hollender[5] did some investigations recently on animals and his results and conclusions are on animals and his results and conclusions are worth noting. He thinks that his results may be evaluated clinically. The injury that comes about usually he ascribes to the use of unphysological solutions. Mosher has described the histopathology in the human nose after similar experiments and says that fibrosis with thinning of the tunica propria, hyperplasia of the epithelium with some metaplasia take place in the mucus membrane of the nose. There is, according to this authority, a partial destruction of the glandular function and a decided increase in the goblet cells. Dean[6] claimed that there was always a thickening of the blood vessel wall especially of the capillaries. Some of the acini of the glands appeared to be obstructed by the cellular hyperplasia. Hollender, whose views are at variance with the above mentioned authors, thinks, however, that the clinical progress following treatment with these drugs should be closely watched and evaluated, as his experimenting was carried out almost entirely with animals.

Another form of treatment which I should like to caution you about is the so called displacement treatment of Proetz.[7] When Dr. Proetz instituted this valuable method of treatment ten years ago and presented it to the profession it was not his intention or thought that it was to be used indiscriminately in all forms of sinus disease; an excel-

lent procedure in certain cases where the diagnosis has previously been established as suitable for its application but how many times have we had people present themselves in the past few years who have been subjected to this form of punishment for months on end when the treatment was obviously surgical.

"Having cleansed my bosom of this perilous stuff which weighs heavy upon the heart" I will conclude with a word of warning against cutting operations in the nose in children either for diagnostic purposes or for treatment. In the case of the former it should never be permissible, in the latter, only after the most careful consideration has been given for its application. Surgical procedures in the nose of children under the age of ten years is seldom necessary.

Attention and regulation of diets constitute an important part of the treatment of children affected with disease in any part of the respiratory tract. These details should be looked to in co-operation with the pediatrician. It has been shown that some individuals with chronic infection have less vitamin C in the blood and urine than normal individuals who take the same amount of vitamin C in their diet. Also some data is presented to show that more vitamin C is needed by people with chronic infection than by normals to bring about an increase of the vitamin C content of the blood.

In older children and in adults when surgery is contemplated the surgeon should have the most complete picture of the state and extent of the sinuses involved. This is possible only by a thorough and complete examination with all the aids which are at our disposal and the correlation of our findings.

## CONCLUSIONS

There is an old erroneous saying "once a sinus always a sinus." I know of no more vicious advice to give a person afflicted with sinus disease. Another favorite is "don't let anyone operate on your sinuses, they will make you worse." This brands the individual, especially the impressionable, in many cases with sinus disease for life.

A thorough knowledge of the anatomy of all the accessory nasal sinuses, as well as the regions in the upper respiratory tract that are tributary to them, is essential before one is justified in attempting to handle the treatment of these difficult cases either surgically or otherwise. Where surgical procedures are indicated they must be carried out, conservatively or radically as the individual case demands.

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## CASE REPORT

### Carcinoma of the Tongue

*From the Tumour Clinic*
*Winnipeg General Hospital*

Mrs. R. age 53, presented herself in January, 1932, with a large fungating tumor of the tongue. She had had pain in her tongue since July, 1931, and the tumor since October, 1931. On examination there was a large tumor on the left edge of the tongue occupying its middle third. The tumor was raised above the level of the tongue about 1 cm. and its diameter was 3.5 cms. The tongue was moveable. The remainder of the mouth was normal. There were some enlarged glands on the left side of the neck but they did not feel indurated. A biopsy of the tongue showed epidermoid carcinoma grade 2. At operation the growth on the tongue was thoroughly coagulated by diathermy. To ayoid secondary haemorrhage from the lingual artery, the submandibular triangle was cleared of its contents, and through the fibres of the hyoglossus the second part of the lingual artery was ligated. Her convalescence was uneventful and three weeks later fifteen mcs. of radon were inserted into the tongue at the site of the tumor.

She failed to return to the Follow Up Clinic until six months later. On examination at this time, her tongue and the operative field in the neck were normal, but there was a large nodule 1 inch in diameter in the upper carotid region. This nodule was stony hard and was fixed in the deeper structures. It failed to regress with a course of X-radiation and a rather large dose of radon was inserted into the nodule. Following a very stormy period of reaction and infection she gradually improved.

Examination now, seven and a half years after the onset, shows a well healed scar in a very mobile tongue; very marked fibrosis in the upper part of the neck, in a patient whose general health is excellent.

### Dr. Raymond C. Parker, Native-born Nova Scotian Heads New Squibb Laboratory

It is announced that a Canadian, Dr. Raymond C. Parker, a native of Newport, Nova Scotia, has been appointed to head the new Squibb laboratory for the study of filterable virus diseases which has been established at New Brunswick, New Jersey. Dr. Parker was educated at Acadia University and at Yale. He also studied for two years in Germany as National Research Council Fellow in Biology. Returning to America, he became assistant in the division of experimental surgery at the Rockefeller Institute in 1930, and five years later associate in collaboration with Dr. Alexis Carrel. His researches have dealt with selection in protozoa and the biology of tissue cells in pure cultures. He is the author of the leading text on "Methods of Tissue Culture." —Advt.


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